Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctor's Hospital of Laredo

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-10-2539-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
January 19, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please submit this claim for the correct allowable, but per the Medicare allowable at 148%."

Amount in Dispute: $73.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charges in dispute for services on 6/6/09 – 6/30/09 are for physical therapy services delivered in an outpatient hospital setting. These have already been reimbursed per the Medical Fee Guidelines using the Medical Physician Fee and 2009 conversion rates. The contract reduction is at 7% as confirmed by the copy provided."

Response Submitted by: Liberty Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 6 – 30, 2009	Physical Therapy Services	$73.11	$73.11

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.
4. 28 Texas Administrative Code §102.4 sets out general rules regarding communications.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Z547 – This bill was reviewed in accordance with your fee for service contract with First Health
   - 42 – Z710 – The charge for this procedure exceeds the fee schedule allowance
   - 150 – Z652 – This service was reviewed in accordance with your contract

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason code 45 – "Z547 – This bill was reviewed in accordance with your fee for service contract with First Health." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. 28 Texas Administrative Code §134.203(c) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is date of service yearly conversion factor.

Date of Service	Submitted Code	Submitted Charge	Units	MAR (TDI-DWC Conversion Factor / Medicare Conversion Factor) x Non-Facility Price
June 9, 2009	97101 GP	$109.50	1	n/a always bundled
June 10, 2009	97101 GP	$109.50	1	n/a always bundled
June 11, 2009	97101 GP	$109.50	1	n/a always bundled
June 15, 2009	97101 GP	$109.50	1	n/a always bundled
June 18, 2009	97101 GP	$109.50	1	n/a always bundled
June 22, 2009	97101 GP	$109.50	1	n/a always bundled
June 24, 2009	97101 GP	$109.50	1	n/a always bundled
June 25, 2009	97101 GP	$109.50	1	n/a always bundled
June 9, 2009	97110 GP	$143.50	2	(53.58 / 36.0666) x 26.83 = 39.93 x 2 = $79.86
June 10, 2009	97110 GP	$143.50	2	(53.58 / 36.0666) x 26.83 = 39.93 x 2 = $79.86
June 11, 2009	97110 GP	$143.50	3	(53.58 / 36.0666) x 26.83 = 39.93 x 3 = $119.79
June 15, 2009	97110 GP	$143.50	2	(53.58 / 36.0666) x 26.83 = 39.93 x 2 = $79.86
June 18, 2009	97110 GP	$143.50	4	(53.58 / 36.0666) x 26.83 = 39.93 x 4 = $159.72
June 22, 2009	97110 GP	$143.50	4	(53.58 / 36.0666) x 26.83 = 39.93 x 4 = $159.72
June 24, 2009	97110 GP	$143.50	3	(53.58 / 36.0666) x 26.83 = 39.93 x 3 = $119.79
June 25, 2009	97110 GP	$143.50	3	(53.58 / 36.0666) x 26.83 = 39.93 x 3 = $119.79
June 3, 2009	97001 GP	$324.75	1	(53.58 / 36.0666) x $67.08 = $99.84
June 15 ,2009	97001 GP	$324.75	1	(53.58 / 36.0666) x $67.08 = $99.84
	TOTAL	$3,175.75		$1,118.07

3. Total maximum allowable reimbursement is $1,118.07. The amount previously paid by the carrier is $1,039.79. The remaining balance is $78.28. The requestor is seeking $73.11. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $73.11.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $73.11 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		November , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.